

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Public Health Service  
Indian Health Service  
Rockville, Maryland 2085

Refer to: OAM

INDIAN HEALTH SERVICE CIRCULAR NO. 92-5

Budget Execution Policy (Allocation of Resources)

Sec.

1. Purpose
2. Authority
3. Definitions
4. Scope
5. Background . . .
6. Summary of Funding Sources
7. Approach
8. Governing Principles
9. Objectives
10. Measurement Indicators
11. Policy
12. Procedures
13. Responsibility
14. Implementation

1. PURPOSE. This circular establishes Indian Health Service (IHS) policy and prescribes the source, philosophy, and procedures to be followed in allocating resources available to IHS. The purpose is to institute a policy that guides allocation of agency resources among areas and operating units in a reasonable and fair manner.

This policy prescribes a resource allocation -framework that is based upon a systematic scientific approach, objective measurement, and a consistent application. The policy establishes the governing framework for IHS resource allocation methods and formulae, which are the instruments that are used to annually distribute designated portions of the IHS appropriation.

2. AUTHORITY. Following are laws, regulations, policies, court decisions, and other sources of reference that pertain to the allocation of resources.
  - A. Money and Finance, Title 31 U.S.C.
  8. Title X of Public Law (P.L.) 93-344, found at 2 U.S.C. 681-688
  - c. Office of Management and budget (OMB) Circular No. A-34, Instructions on Budget Execution

Distribution: PSD 557 (Indian Health Service Mailing Key)  
Date : June 19, 1992

- D. Title 2, General Accounting Office (**GAO**) Policy and Procedures Manual
- E. Department of Health and Human Services (**HHS**) Chapter 2-10, Departmental Accounting Manual
- F. **Snyder Act', 25 U.S.C, 13**
- G. Indian Health Care Improvement Act as amended **by** P.L. 96-537, P.L. 100-203, **and** P.L. 100-713.
- H. Public Law 93-638 as amended **by** P.L. 100-202, P.L. 100-446, P.L. 100-472, and P.L. 200-581.
- I. Annual Appropriation Acts and their relative House, Senate, and Conference Reports.
- 3. Public Law 86-121 (provision of water and waste disposal facilities to Indian **homes, lands,** and communities).
- K. Public Law 99-570 (The Omnibus Drug Bill) **as amended by** P.L. 100-690.
- L. Other pertinent laws and statutes.
- M. Court decision in Rincon Band of Mission Indians v Harris - 618F.2d 569 (1980).
- N. **IHS policy on** Resource Allocation Methodology (superseded by this policy)

3. DEFINITIONS.

Administrative Control of Funds -- The formal **system** and procedures for controlling the obligation and disbursement of Federal funds in accordance with law and regulation.

Advice of Allowance -- Formal **delegation** of' authority (**below the allotment level**) to employees of IHS to enter into **obligations** for a specific **amount and** purpose that will result in **immediate** or future outlays of Federal **funds**.

Allotment -- Formal delegation of authority to the Director, IHS, to enter into obligations on behalf of the Federal Government pursuant to OMB apportionment **and** other statutory authority making funds available for **obligation**.

Alternate Resources -- Resources used for the health care of Indian people that do not **come** from **the** funds appropriated to the IHS.

Antideficiency Act -- Law that prescribes the Fund control objectives for Federal agency accounting. The principle purposes are: (1) to prevent obligation and disbursement in excess of the amounts appropriated, apportioned, and balances available, (2) to fix responsibility within an agency for excess obligations and expenditures, and (3) to assist in bringing about the **most** effective and economical use of appropriations and funds.

Apportionment -- A distribution of available funds by **OMB** to agencies usually on a quarterly basis that is intended to achieve an effective and orderly use of funds over the course of the entire fiscal year.

Appropriation -- **An** authorization by an Act of Congress that permits Federal departments and agencies to incur obligations and to make payments **out** of the United States (U.S.) Treasury for specified purposes. Appropriations do not represent cash actually set aside by the Treasury. They are limitations **of amounts** that agencies **may** obligate during the specified time period.

Area -- A defined geographic region for IHS administrative purposes. The Area Office administers the operation of several service units.

Authorization -- The basic substantive legislation that sets up or continues the legal operation of Federal programs or agencies either indefinitely or for a specific period of time. Authorization does not enact resources for operations.

Base Funding -- An amount of budget authority that is likely to be continued in the following year's appropriation and program.

**Benchmarks** -- Point of reference or standard from which measurements can be made. In IHS resource allocation formulae, benchmarks are selected as thresholds for computing the allocations to Areas. For example, the authorizing legislation for the Indian Health Care Improvement fund set a benchmark of 60 percent funding sufficiency as a prerequisite for participating **in the** first round allocations.

Budget Activity -- Categories included in the budget for each appropriation and fund account that identify the services to be performed or program activity.

Built-In Increase -- A funding increase in a budget request or budget authority to compensate for *known* and predictable increases in program costs because of inflation and other causes. The OMB prescribes specific standards for projecting such amount when formulating agency budget.

Consultation -- The active engagement of tribes and tribal organizations in establishing policies, setting priorities, and governing **the** overall health care delivery system for Indian people.

Continuing Resolution -- Temporary budget authority enacted by the Congress to provide for ongoing activities when the regular appropriation has not been enacted in time. It specifies a maximum rate for incurring obligations.

Contractor -- Contractors of federal programs pursuant to P.L. 93-638 as amended. The term contractor is limited to the special,, case in which a tribe or tribal organization operates a program that provides or finances health care services to Indian communities within a geographic, area for which it is responsible.

cost -- The financial measure of resources consumed in accomplishing a specified purpose.

Cost Differential -- A documented difference in cost or price for the same service or product. For example, Federal statute allows for a 25 percent Cost of Living Adjustment (COLA) in the salaries of Federal employees located in the State of Alaska.

Cost Allocation -- The assignment and reporting of expenses in a systematic way to a program function or service in order to identify the resources consumed in producing a service. For example, the overhead costs of a personnel system are often allocated among other departments in proportion to the number of staff in each department. After the costs of all supporting operations are allocated in a similar way, the true costs of providing a service may be estimated.

Council -- Council of Area and Associate Directors.

Current Services -- An assumption used during budget formulation that prescribes the continuation of program operations at a level sufficient to maintain the number and quality of services provided in the previous fiscal year.

Disposition of Funds -- The final arrangement and use of funds.

Earmarks -- Funding identified in an appropriation act that specifies purpose, object or use, disposition, and timeframe in greater specificity than is provided in the authorizing legislation. In the IHS appropriation Acts, earmarks frequently identify a specific project, tribe, or site to which funds must be directed.

Effectiveness -- The degree that a program accomplishes its intended purpose. It is often measured by the change or effect on the external targeted condition per unit of program output.

Efficiency -- The degree that a program produces work or outputs within prudent costs and resources. It is often measured by the number of work units or outputs per unit of resource Input.

Equity.-- The state of being equivalent with respect to some property and/or the freedom from bias and favoritism. There is no single absolute measure of equity with regard to health care for Indians. There are a number of indices used in the health industry (e.g., funding per person, service capacity per person - beds or physicians per 1,000, services per person, access time, health conditions, health status outcomes). Several of these measures are often employed simultaneously in IHS resource allocation formulae.

Expenditures -- A term generally used interchangeably with outlays.

Fiscal Year -- Any yearly accounting period. The fiscal year for the Federal Government begins on October 1 and ends on September 30 of the following calendar year.

Fund Control -- A term referring to management/administrative control over the use of authorization, obligation, and disbursement of funds to ensure that (1) funds are used only for authorized purposes, (2) they are economically and efficiently used, and (3) obligations and expenditures do not exceed the amounts authorized.

Formulae Manager -- The official responsible for the application of IHS allocation methodologies and formulae. The formulae manager for national allocations is designated by the appropriate Associate Director. See Section 13 for a list of Headquarters offices with designated formulae managers. The Area Director designates formulae managers within Area Offices.

Health Status -- The relative degree of health, or lack of health, for a defined service population. Several indices of health status have been identified in the public health literature (e.g., infant mortality rates, life expectancy at birth, years of productive life lost (YPLL), incidence and prevalence of diseases, functionality and life quality indices, etc.), but there is little consensus for a single best health status Index. The IHS resource allocation formulae use a variety of health status measures.

Health Care Services -- Any of various types of work performed by health care professionals to benefit individuals that does not produce a tangible commodity. Services are normally measured by several industry accepted indices such as hospital admissions, patient days, patient encounters, etc.

Indians -- A name used throughout this document to identify American Indians and Alaska Natives.

Mandatories -- A term, interchangeable with "built-in increases," referring to budgetary increases justified on the basis of known or predictable increases in costs because of inflation and related factors.

Non-Recurring Funding -- Funds allocated to Areas, service units, contractors that do not constitute a permanent or continuing commitment. Funds are allocated on a non-recurring basis if the funds or program activity are not expected to continue in subsequent years or to reimburse fluctuating and unpredictable expenses.

Norms -- An authoritative standard derived from the average or median attributes or behavior of large groups. Norms derived from IHS or U.S. population averages are frequently used as benchmarks in IHS resource allocation formulae to guide and regulate allocations. For example, the average rate for Years of Productive Life Lost (YPLL) is a benchmark that is used to determine the degree to which health status in Indian communities falls short of the U.S. average.

Object Classification -- A classification identifying financial transactions by the nature of the goods or services purchased (such as personnel compensation, supplies and materials, equipment, etc.) without regard to the purpose of the programs for which they are used.

Obligations -- Amounts of orders placed, contracts awarded, services rendered, or other commitments made by Federal agencies during a given period, that will require outlays during the same or some future period.

Obligational Authority -- Authority delegated to a Federal official to enter into financial obligations for a specific amount and purpose that will result in immediate or future outlays of Federal funds.

Operating Units -- A generic term identifying organizational/operational units providing or financing health care services for Indians who reside in a defined geographic area. The term is used throughout this policy to refer to organizational units such as Federal service units, tribally operated service units, tribal contractors, and 638 contractors.

Outlays -- The amount of checks issued, interest accrued on debt, or other payments; net of refunds and reimbursements. Federal outlays are generally recorded on the "cash basis of accounting" -- with the exception of most interest on the public debt.

President's Budget -- A consolidated budget and financial plan for the Federal Government that is recommended by the President and transmitted to the Congress within 15 days after the start of each new legislative session in January.

Productivity -- Relates to the volume of work, products, or services compared to the funds or resources used. Productivity is generally used interchangeably with efficiency. It is frequently measured by a ratio of the number of units of output (products or services) per unit of

input (funds or resources). Productivity is increased when outputs are expanded while resources are maintained constant or when outputs are maintained constant while resources are reduced.

Program -- An organized set of activities directed toward a common purpose, objective, or goal, undertaken by an agency, in order to carry out responsibilities assigned to it.

Program Increase -- Budgetary term referring to a real expansion in a program's scope or services above current levels. It is used to distinguish funding necessary to expand productive or service capacity compared with the funding necessary to maintain capacity in the face of rising costs and inflation.

Recurring Base -- Funds are designated as recurring if it is likely that appropriations will be continued in the next year and the program, by its purpose and design, will be operated continuously to ensure maximum effectiveness. The cumulative sum of recurring allocations is called the recurring base.

Reimbursements -- Funds received for commodities sold or services furnished either to the public or to another government account that are authorized by law to be credited directly to specific appropriation and fund accounts.

Reserves -- Portions of funds or budget authority that is apportioned to the IHS that is not immediately allocated for obligation and is set aside for use later in the year. Reserves are set up to cover emergencies, unplanned contingencies, or to reimburse expenses after the amounts become known.

Resource Allocation Formulae -- The mathematical rules and procedures used to compute specific amounts of funding for areas or operating units. There are several IHS resource allocation formulae, some with multiple variations, that correspond to the various programmatic or budgetary divisions. The IHS resource allocation formulae codify the decision rules that are used to subdivide specifically identified pools of resources. Formulae are not generally used to determine all of the funding that may be allocated to areas or operating units to provide services.

Resource Allocation -- The decision making principles, rules, and procedures use to sub-divide IHS resources among operating entitles.

Service Unit -- A local administrative unit that operates programs providing or financing health care services for Indians residing in a defined geographic area. Service units may be operated either directly by the IHS or by a tribe or tribal organization.

Service Population -- The number of American Indians or Alaska Natives identified as eligible for IHS services who reside in a defined geographic service area. The service population count measures the number of eligible people who would customarily receive their health care services from a designated operating unit. The potential service population is typically estimated or projected from the latest U.S. Census enumeration. The service population estimate of potential users often exceeds the count of actual users. However, if the actual number of users identified in official operating unit records, such as the IHS patient registration system, exceeds the service population count estimated from Census data, then the active user count is also used as the service population count.

Sub-Area Allocations -- Allocations of funds among the constituent operating entities (service units, and contractors, etc.) within an IHS area.

Sub-Sub-Activity -- A secondary subdivision of a budget activity that identifies the function to be performed or the services to be provided (Examples of sub-sub-activities in the IHS budget are Hospitals and Clinics, Dental Programs, Contract Health Services, Alcohol and Substance Abuse Programs, etc.).'

Unmet Need -- Need is the lack of something requisite, desirable, or useful. The term unmet is customarily used in conjunction to further emphasize the shortfall or lack of requirements considered necessary for the health and well being of Indian people.

User Population Estimate -- The count of those American Indians and Alaska Natives who are registered in the official patient registration system of an operating unit and who had at least one direct or contract hospital stay or outpatient or dental visit in a specific 3 year period.

#### 4. SCOPE.

- A. This policy applies to appropriations made available to the IHS for the health programs for American Indians and Alaska Natives.
- B. Applicable statutory, judicial, regulatory requirements governing the allocation and use of health service appropriations and/or reimbursements to the IHS take precedence over this policy if inconsistencies exist.
- C. Resource allocation, as defined in this policy, has a particular meaning that is to be distinguished from other common uses of the term. In our use of the term, resource allocation means the decision making-principles, rules, and procedures that are used to

sub-divide resources among areas and operating units prior to their use and expenditure. The decision making process is distinct from and precedes the administrative process in that authorities to expend funds are communicated and delegated among the recipients via formal allotments and advice of allowances. Policies covering these processes are covered in a separate policy issuance "Administrative Control of Funds Policy."

- D. This policy governs the distribution of resources among the 12 regions (designated as Areas) served by the IHS and among the health care facilities, service units, operating units, or communities within each Area, whether directly operated by the IHS or under contract with Indian tribes or Alaska Native corporations. This policy does not govern decisions about the purpose and activities to which resources may be assigned nor does it prescribe the number and types of health care programs, goods, or services (e.g., acute inpatient care, chronic care, dental care, eye care, etc.) that are purchased. This policy does not establish priorities for or entitlement to health care by individual persons eligible for IHS services. Nor does it establish the amounts of resources that may be used to finance the services individuals receive from the IHS or its contractors. Such issues are generally covered by statute, appropriation, other regulations, or are matters of local discretion.
- E. This policy establishes the general framework that governs IHS resource allocation decisions. Detailed description of the various formulae, data definitions and sources, internal procedures used to tabulate and compile data, and computational algorithms are not included here. These details are found in other IHS publications such as "Resource Allocation Abstracts" and other procedural manuals and documents.

- 5. BACKGROUND. A critical element in the delivery of health care to the American Indians and Alaska Natives is the management of the IHS program. The complexity and geographical dispersion of the IHS program requires a decentralized management system that permits decisions to be made at the organizational level closest to the sources of information and expertise thereby creating flexibility resulting in more timely and appropriate responses to unique situations. The management of IHS programs is accomplished through an organizational structure and hierarchy that includes Headquarters, Area Offices, and service units or an equivalent. The Headquarters consists of a component located in Rockville, Maryland, with functions being carried out by the Director, IHS, as the Agency Head and leader along with supportive staff; another component located in Albuquerque, New Mexico, with functions carried out by the Program Director, Headquarters West as the leader along with supporting staff; and finally a component located in Tucson, Arizona,

with functions carried out by the Associate Director, Office of Health Program Research and Development (OHPRD) as the leader along with supporting staff. Area Offices are currently functional in 11 locations strategically located on or near the, American Indian and Alaska Native reservations or communities with responsibilities based on geographic boundaries. Service units or their equivalent represent organizational units within the Area Office organizational structure. ,

The role of IHS Headquarters is two-fold: First, to carry out the authorities, functions and responsibilities of a Federal agency; and, secondly, to direct, monitor, coordinate and evaluate management activities carried out by the 11 Area Offices. The Director and attendant staff coordinate the IHS activities and resources with those of other Federal and local programs.

Area Offices are responsible for carrying out a dual function: First, to participate in and establish goals and objectives, applying IHS policies, and determining priorities within the framework of IHS policy in support of the IHS mission. Such as, Area Offices coordinate their respective activities and resources internally and externally with those of other governmental and nongovernmental programs to promote optimum utilization of all available health resources.

Secondly, Area Offices ensure the delivery of quality health care through their respective service units, and participate in the development and demonstration of alternative means and techniques of health services management and delivery to provide Indian tribes and other Indian community groups with optimal ways of participating in Indian health programs. As an integral part of this dual function, the Area Offices are principally responsible for ensuring the development of individual and tribal capabilities to participate in the operation of IHS programs commensurate with the means and modalities that Indian tribal groups deem appropriate to their needs and circumstances.

A critical management function of Area Offices is the coordination and support provided to their respective service units. Administrative management support functions include acquisition, financial, personnel, material, and facilities management. Program management support includes professional leadership in medicine, dentistry, nursing, pharmacy, laboratory, radiology, etc.

Service units carry out the vital IHS mission and responsibility of the delivery of health services at the local level. The service unit delivery system includes a combination of direct care provided by health care professional staff and contract referrals to private vendors of health care services. The size and scope of the service unit programs vary according to the size and health needs of the respective service populations.

- 6, SUMMARY OF FUNDING SOURCES. The Indian Health Service operates almost entirely with resources provided by the Indian Health Services and Indian Health Facilities appropriations, collections from the States and the Health Care Financing Administration (HCFA) for services provided to Medicaid/Medicare eligible American Indians and Alaska Natives in IHS facilities, and collections from other third party payers such as private insurance carriers for services provided in IHS facilities to Indians with third party coverage.

The IHS appropriation, collections from States and HCFA, and collections, from other third party payers, are the main source of funds for supporting the cost of the day-to-day operational activities of IHS. This includes the cost associated with the delivery of clinical and preventive health services including inpatient, outpatient, dental, mental health, alcoholism and substance abuse, environmental health, and other community health services being accomplished through direct IHS operated programs and contractor operated programs, involving both tribal governments and the private sector. It also involves the support of the urban health projects, the operation of the Indian health manpower program, the tribal management program, and supports the administrative and program management activities at Headquarters and Area Offices. The administrative and program management activities involve both health services and health facilities (construction) operations.

The Indian Health Facilities appropriations contain the resources that supports the construction activities of IHS. This includes the construction of hospitals and clinics, repair and improvement of existing clinics, personnel quarters, and sanitation facilities involving water and sewer systems. These funds are normally project-specific and generally consistent with the IHS facilities priority system.

- A. Indian Health Service Appropriation. The Indian Health Services appropriation that supports the day-to-day operation of IHS, as described above, is an annual appropriation. This means that, with a few exceptions, the funds appropriated are available for obligation for the period of the specific Federal fiscal year only.

Since these funds or obligational authority expires on September 30 (end of fiscal year) and since the management of IHS and the day-to-day activities associated with the delivery of health services along with their administrative support functions require financial support on October 1, it is imperative that decisions determining the level of funding that will be available at the beginning of the new fiscal year be made prior to October 1 of each year.

The total Indian Health Services appropriation is allocated to the 14 separate management entities as described above including 11. Area Offices. These resources are allocated by budget sub-sub-activity as either recurring or non-recurring.

Funds are considered and allocated as recurring if a determination is made that it is **most** likely that these funds would be continued in the following year's appropriation and the program for which the funds were appropriated, by its purpose or design, would be needed on a continuing basis at the Area level to ensure its appropriate applicability and maximum effectiveness. For example, this would include resources appropriated to support unmet needs for staffing and operating cost of health facilities. Since it is obvious that additional staff for hospitals and clinics are needed on a continuing or permanent basis, any additional funds appropriated for this purpose would be allocated as recurring thereby informing the respective Area Director of the plan for the funds to be continued in the following fiscal year's allowance.

Through this technique, Headquarters and Area Office operations' attain and **maintain** a recurring funding base for each budget sub,-sub-activity. This provides a funding base level for which IHS Area Directors and other recipients of allowances can expect to receive, subject to adjustments based on congressional actions and/or other decisions of IHS, and provides the following management needs:

- (1) A base for measuring the amount of resources available to fund health care needs,
- (2) A funding base of reference for negotiating renewal of tribal contracts,
- (3) A base of reference for IHS managers in planning operations, and
- (4) A reference for measuring progress.

Funds to support activities on a non-recurring basis are identified and maintained **in** Headquarters to be allocated throughout the year in accordance with an approved plan. This plan describes the program, project, or activity to be funded along with the methodology and time schedule for allocating the resources. Upon approval by the Director, IHS, this plan is executed accordingly. These non-recurring activities include such items as special training programs, **evaluation** projects, special recruitment endeavors, etc.

In addition, funds are retained in Headquarters as undistributed reserves to support contingencies for urgent and/or emergent needs; For example, the replacement of emergency equipment that could be life threatening such as ,resuscitators, x-ray machines, boilers, emergency room equipment could be supported from this fund. The allocation of these funds are carried out upon review and approval by the Director, IHS or his designee. The review and approval process includes recommendations from an Associate or Area Director and/or other IHS staff.

- B. Collections from States and HCFA. In regard to collections from HCFA and the States for Medicare/Medicaid reimbursements, Title IV of P.L. 94-437, Access to Health Services, Indian Health Care Improvement Act, states that IHS shall be eligible to receive payments for services rendered to eligible Indians, who are entitled to care under Title 18 and Title 19 (Medicare and Medicaid).

The Act further specifies that the funds shall be used "exclusively for the purpose of making any improvements in the facilities or such service which may be necessary to achieve compliance with the applicable conditions and requirements of the Act.<sup>a</sup>

All IHS hospitals are surveyed by the appropriate agency [Joint Commission on Accreditation of Healthcare Organizations/Health Care Financing Administration (JCAHO/HCFA) and the results of these surveys are used to formulate a plan of correction of any deficiencies. This plan addresses each deficiency in terms of personnel services costs, equipment needs, or maintenance and repair project needs to correct the cited deficiencies. In addition, the facilities are reviewed for compliance with any new standards that may occur and any additional or new needs are incorporated into the annual plan.

These funds become available throughout the year as services are provided to Medicare/Medicaid eligible Indian patients in IHS facilities, bills are issued, and the resultant collections are received. These funds are apportioned as estimated reimbursements and are available for allocation shortly after collection is accomplished.

To ensure that IHS is in compliance with all of the applicable laws, regulations, and policies, these funds are allocated to the Area where the collection was made to be used for deficiencies in accordance with an approved corrective action plan.

- C. Collections from Private Insurers. The IHS has the authority under P.L. 100-713 (The Indian Health Care Amendments of 1988) to bill and collect from private **insurers** for services that are provided to eligible Indian patients treated in IHS facilities. Section 207 (a) of P.L. 100-713 states that ". all reimbursements received or recovered, under authority of this Act, . . . by reason of the provision of health services by the Service or by a Tribe or tribal organization under a contract pursuant to the Indian Self-Determination Act shall be retained by the Service, or **that** Tribe or tribal organization and shall be available for the facilities, and to carry out the programs, of the Service or that tribe or tribal organization to provide health care services to Indians."

Similar to collections received from States and HCFA, funds from private **insurers** become available throughout the year as services are provided to eligible Indian patients in IHS facilities, bills are issued, and the resultant collections are received. These funds are also apportioned as estimated reimbursements and are available for allocation shortly after the collections are received.

As stated **above**, **these** funds are allocated to the Areas to provide health **care** services in accordance with the President's budget as approved by Congress.

- D. Indian Health Facilities Appropriation. The Indian Health Facilities Appropriation contains the resources that support the direct construction of IHS facilities including hospitals, outpatient care facilities, personnel quarters, regional youth treatment centers, and sanitation facilities. In addition, resources are included to fund the administration and management activities supportive of construction including maintenance and repair, environmental health, and the cost of construction support staff located in Headquarters, Area Offices, and other 'locations.

The **Indian** Health Facilities appropriation is a no-year appropriation thereby authorizing the funds contained therein to be available for obligation until they are expended. Since these funds are normally earmarked for specific projects, the allocation of these resources are made **based** on need as determined by the phase, stage, or status of the projects. For example, funds are allocated in a manner that ensures the continuation of projects without unnecessary delays.

These funds are allocated to the appropriate Area Office for projects that will be accomplished **by** tribes under authority of P.L. 93-638 (Indian Self-Determination Act) and for projects that

are to be administered by IHS staff. Funds for other projects are maintained, and managed by Headquarters: The authorization for awarding, executing and administering contracts to complete the projects is issued to the HHS Regional Offices.

7. APPROACH. The IHS resource allocation policies established a systematic method to fairly evaluate the competition for resources among the areas, service units and/or contractors. Objective data are brought to bear in a prescribed orderly fashion to assist decision makers in choosing the optimum distribution of resources.

The IHS resource allocation methods are of two basic types: 1) competition that occurs prior to and during the budget formulation/appropriation process, and 2) competition that occurs after appropriations are set. In the first case, funding proposals for specific projects or activities are developed and justified as part of the IHS budget. These "decision units" compete with other alternatives throughout each phase of this extensive process. Typically, a proposal must survive many face-to-face evaluations, both in the Executive Branch and in the Congress before it is funded. For example, prospective projects for new and replacement facilities compete within the IHS by using a system formal ranking criteria known as the Health Facilities Priority System (HFPS). Those projects that are ranked highest in priority are submitted for funding in a budget the IHS proposes. During subsequent reviews of the IHS budget within the Public Health Service (PHS), Department of Health and Human Services (HHS), and the OMB, each of these projects must survive several rounds of evaluation against competing priorities before submission to the Congress. The Congress also considers the merits of these and other proposals. The competition ends when the Congress appropriates funding for specific projects and activities. After appropriations are specified, there is no further competition for such "earmarks." The IHS merely implements the project or activity.

The second major type involves competition among Areas, service units and/or contractors for unearmarked appropriations. This competition occurs after the appropriation is set and does not affect the total amount of resources made available to the IHS. In this case, the Congress makes available funding for a general purpose or program, but does not identify amounts for specific projects or sites. The agency is granted discretion to choose an allocation method that best fulfills the legislative intent. Various methods and approaches are used to subdivide unearmarked appropriations among Areas and, in turn, among service units, and contractors.

- A. Appropriation Earmarks. Congress frequently specifies, in the language of an appropriation act or in the conference report that accompanies an appropriation, funding amounts to be used for a specific purpose, project, or site. For example, specific amounts i., may be designated to construct, equip, staff, and operate a new or replacement health clinic for a particular tribe. Directives in the appropriation language carry the force of law and IHS must establish necessary procedures and controls to ensure compliance, sometimes on a case-by-case basis. Little, if any, resource allocation discretion is delegated to the IHS. Directives in report language, but not the appropriation act, do not carry the force of law. Normally, the agency carries out such directives by exercising some discretion as to the best method to achieve the expressed intent.
- B. Statutory or Regulatory Mandates. Laws other than appropriation acts sometimes establish special requirements and guidance for the allocation and use of resources. Restrictions on the use and allocation of reimbursements from HCFA and States is one example. Criteria for competing scholarship and loan repayment applications is another. Standards and procedures to reimburse the expense of high cost cases under the catastrophic Health Emergency Fund (CHEF) is a third example. The IHS typically establishes separate policies and procedures to govern the allocation and control of funds that fall under such statutory mandates. Although the law establishes the purpose and broad guidelines for such resources, the Congress frequently depends upon the experience and expertise of the agency to prescribe the method to best achieve the program objectives.
- C. Recurring Base Funding. Base funding is that amount of funding that is likely to be continued in subsequent years for the program or services originally authorized. If the annual IHS "base" appropriation is not reduced, Area and operating units may expect to receive recurring base allowances, subject to adjustments based upon congressional actions and/or other decisions of IHS, that are equal to their base funding amount at the end of the previous fiscal year.
- D. Built-in Increases. Built-in increases (often referred to as mandatories) are additional funding, above the base funding amount, appropriated to compensate for inflation and other cost increases. These amounts are appropriated to maintain current levels of services in the face of increased costs and are not expected to enhance or expand program services. As a general rule, if appropriations include built-in increases, such amounts are allocated by a fixed percentage applied to the base funding amount (i.e., all recipients receive the same percentage increase).

- E. Formulae Methods. The IHS allocates resources appropriated to reduce unmet need or to otherwise expand services on the basis of standardized formulae that have been developed and reviewed in consultation with Indian tribes, IHS management, and health program officials. This policy explains and governs the allocation of resources by these formulae methods.
- F. Operating Reserves. Occasionally, unpredictable 'crises and emergencies occur that require resources in excess of a service unit or contractor's annual budget (e.g., replacement of failed major medical equipment). The standard financial practice is to place a small percentage of the total annual budget into operating reserves to cover unanticipated contingencies. The IHS Headquarters and Area Offices will set aside reserves for this purpose. Such reserves will be allocated on a case-by-case basis for emergencies in amounts consistent with restoring capacity for normal operations and preserving safety of patients. Any unallocated reserves at the end of the fiscal year will be allocated by one of the other approaches described above.
- G. Reimbursement of Variable Expenses. Some expenses incurred by health care programs fluctuate from year-to-year (e.g., costs to relocate employees depends on the number of employees who move in a given year). While the total costs for the IHS may be relatively stable over time, the amount for individual facilities or Areas can vary significantly. In response to these uncertainties, Headquarters may set aside reserves for variable expenses at the beginning of the fiscal year. Areas are later reimbursed on a non-recurring basis when the actual costs become known sometime later in the fiscal year.
- The Division of Resources Management (DRM), IHS, establishes the basis and required documentation for reimbursement requests. If designated reserves are sufficient to cover all reimbursement requests, then the full amounts are allocated. If reserves are insufficient, then reimbursements are made in proportion to the documented expenses incurred.
- H. Special Initiatives. Some important activities require action and funding outside of the normal resource allocation track that leads from Headquarters to Areas and from Areas to service units, and contractors. Because of the unusual and unpredictable nature of special initiatives, formal resource allocation formulae will not generally apply. For example, funds to reimburse exceptional expenses for Indian Acquired Immune Deficiency Syndrome (AIDS) patients, funds to automate financial accounting systems or install system wide computer capability may be set aside and managed at IHS Headquarters.

Because the budgetary and legislative history for some special initiatives is known, an exact amount of funding may be set aside at the beginning of the fiscal year. Other special initiatives may arise during the fiscal year.' Funding for these must' be formally approved by the Council.

An amount may be established by the Council for discretionary use on especially meritorious projects that may arise during the year and are deserving of immediate funding. Generally, the Director, IHS, is the decision making authority for such projects.

- I. Allocation of Decreases. In A - H above, the various approaches to allocating base and additional funding is described. If insufficient resources are available to maintain recurring base funding at existing levels, a net decrease in allocations to Areas, service units, and contractors will result. In general, funding reductions should be absorbed and/or distributed among operating entities in a manner that minimizes the overall negative impact. In the event of funding reductions, this policy will be applied under the following special conditions:
  - (1) Legislative Directives. The agency will manage and allocate net funding decreases according to prescriptions and directives in statute, appropriation acts, and reports accompanying appropriation acts. These include the conditions for reducing the base funding of tribal contractors prescribed in P.L. 93-638 as amended.
  - (2) General Decreases. General reductions of IHS funding, such as occurs when amounts are sequestered by the OMB to meet targets of the Graham/Rudman/Hollings Act, will be allocated by fixed percentage applied evenly to the base funding amounts of' Areas and operating units.
  - (3) Directed Decreases. If decreases are focused on specific activities, such decreases will be allocated by considering the amount of resources used for that activity, in each Area or operating u nit together with assessments of the likely negative impacts.
  - (4) Formulae Methods. Application of many resource allocation formulae "in reverse" to distribute decreases instead of increases is technically possible. Since minimization of harm is the governing principle, results from reverse application of existing formulae should be considered together with other supplemental information on the negative impacts of program constrictions and reductions.

8. GOVERNING PRINCIPLES. Over the years, IHS has developed its resource allocation methods around several broad principles. These principles govern both the decision rules contained in the various IHS formulae and the method of application.

- A. Decentralization. The IHS is a broad, multi-discipline health care organization operating throughout much of the U.S. under diverse and special conditions. The response to these conditions has been to decentralize the organization to allow programs to tailor their efforts to **meet** the unique needs of local Indian communities. Consequently, the IHS resource allocation policies allow local decision making to the maximum practical extent and to the extent allowed by statute.

In practice this means IHS Headquarters generally subdivides the IHS appropriation among IHS Areas. Areas, in turn, subdivide their allocation among service units and tribal contractors, **using** the same policy and approach applied by Headquarters, but with the flexibility to modify and revise the formulae and data according to local needs. Decentralization is also consistent with the spirit of 'Self-Determination\*' in that it allows enhanced opportunity for tribes to **be** directly involved in regional and local decisions affecting their health care programs

8. Tribal Consultation. Tribes and Indian people have several important roles in determining IHS resource allocation strategies and policies. First, tribes contribute to setting funding priorities during the formulation of the INS budget and through direct input to the Congress during hearings. Second, in between annual allocations, tribes and tribal organizations may comment on and/or serve on committees and task groups appointed by the IHS to revise resource allocation formulae. Third, during annual application cycles, tribes and tribal health organizations may review and comment on the accuracy of data and contribute to corrections as appropriate. Fourth, once funds have been placed into an operating unit budget, affected tribes or Indian people should be consulted regarding their priorities and desires for the most appropriate uses of those funds.
- c. Incremental Approach. Since the pivotal RINCON case in 1980, IHS has followed the principle of a phased incremental approach to reducing funding discrepancies. Its purpose is to minimize disruptive hardships resulting from abrupt and precipitous shifting of funds and to provide for a measured orderly growth. Application of this principle has meant minimal annual reallocation of "base" funding. In practice, IHS has attempted to maintain services at levels that were originally committed and the Indian communities have come to expect. This principle also

regulates the "velocity" of change. Funds are generally allocated among competing Areas and operating units in proportion to the degree of deficiency. Regulation in this way modulates the inefficiencies that result from unstable, fluctuating budgets and provides for a greater level of consensus by including a maximum number of tribes and communities in the receipt of such allocations.

- D. Special Conditions. The special conditions and practices under which health care is delivered to Indian people will be considered in resource allocation formulae and methods. Much of the IHS service population lives on or near remote reservation lands. Often they are without basic sanitation services, such as safe water and adequate waste disposal facilities. For many, the IHS is the only source of health care.

The IHS approach to these special conditions is based on a public health model that extends beyond basic medical services to include the construction of sanitation facilities, public health nursing, mental health, alcohol and substance abuse treatment and prevention, community education and outreach, nutrition, and health promotion. The IHS resource allocation methods and formulae are tailored to the unique conditions and characteristics of IHS health care programs. Recognition of the breadth, diversity, and isolation of health care programs for Indians inevitably leads to a level of complexity not faced by traditional health delivery systems that focus largely on medical services.

- E. Alternate Resources. The IHS funding policies have long reflected a principle that Federal funds are residual to third party and State resources when financing health care obtained by Indian people from private providers. Services provided by IHS are not entitlements, such as with Medicare, but depend on a yearly discretionary appropriation. To extend the benefits of IHS resources to those most in need, the IHS has been directed by the Congress in the 1988 Amendments to the Indian Health Care Improvement Act, P.L. 100-713, to consider all alternate resources as available to Indian people for the purpose of measuring their unmet needs. While this directive specifically applies only to the funds authorized by this Act, it does express, by extension, the broader intent of the Congress.

Although there are many practical obstacles accurately measuring all such resources, the IHS cannot disregard the fact that alternate resources do meet a part of what would otherwise be an unmet health care need and; therefore, must be considered in any equitable distribution of resources. This does not mean that such alternate resources will be tapped or reduced by the IHS.

Nor does it mean that base funding will be offset in proportion to alternate resources, unless the total IHS appropriation is reduced and the Congress directs their consideration in apportionment of the reductions. It means that the IHS will consider, to the extent that is practical, resources from all sources in determining priority for IHS allocations. Consideration of alternate resources in this way indirectly diminishes the chances for funding increases.

In those resource allocation formulae that explicitly consider any, available resources as part of the computation, the following alternate resources will be included, as a minimum, in the determination of unmet needs.

- (1) Annual reimbursements (revenue) from HCFA for services rendered by IHS or IHS contractors to Indian patients eligible for Medicare benefits,
- (2) Annual reimbursements from States for services rendered by IHS or IHS contractors to Indian patients eligible for Medicaid benefits, and
- (3) Annual reimbursements from third party insurers for services rendered by IHS or IHS contractors to Indian patients with such benefits.

Alternate resources should be included only if the resources were used, directly or indirectly, for a program or services consistent with those represented in the resource allocation formulae. For example, medicare reimbursements used to maintain hospital accreditation would not count in the determination of the total resources available for community sanitation projects. Likewise, funding for programs or services that are outside the normal scope of services provided by IHS programs would count neither as part of the funding needs projected in a formulae nor as part of resources available in that formulae.

The issue of 'alternate resources continues to attract attention, both as a question of principle and as a question of practice in measuring availability of such resources. The instruments to measure and represent alternate resources continue to evolve. It is possible in the near future that instruments based upon employment and other economic factors will provide alternate resource data that is much improved over that used today. When that happens, the details of this sub-section may be changed to accommodate the new approaches.

- F. Data. Because IHS resource allocation formulae are tailored for a comprehensive health care delivery system, a large variety of data are used to measure the diverse and special conditions that the IHS programs operate. These data are obtained from a variety of sources (e.g., service population estimates and socio-economic data from the U.S. Census, user population counts and demographic data from the IHS Patient Registration Systems, vital events (natality and mortality) data from the National Center for Health Statistics, workload data and patient care statistics from program information and patient encounter data systems, cost and resource data from IHS and contractor financial systems, and various surveys of health and environmental conditions).

When applying resource allocation formulae, the appropriate level of data detail and specificity depends on the value of the information gained relative to its cost. It should be recognized that IHS resource allocation formulae are constructed to detect and remedy significant disparities among Areas, and operating units. Generally, data for resource allocation formulae should be derived from existing sources that are commonly and readily available in IHS or tribally operated programs.

Complete and up-to-date information from all sources is rarely available on the same schedule (e.g., some financial information is available within weeks after accounts are closed while vital events statistics are routinely several years old). This poses some problems for timely application of allocation formulae. In general, data used in IHS resource allocation formulae should represent the most recent year in which full and complete information is available. Although desirable, in many cases it is not possible to guarantee that all data used in a formula come from the same year.

Moreover, in isolated cases in which key data are unavailable for reasons beyond the control of responsible officials, estimates consistent with IHS experience under comparable circumstances may be computed and used for the duration of that resource allocation cycle. Every effort must be made to remedy the data problem for subsequent applications, however. If there is convincing evidence that data are willfully or negligently withheld or reported in error, then that Area or operating unit may forfeit participation in the resource allocation formulae or, alternatively, participation may be limited commensurate with the severity of the infraction.

Absolute guarantees of data uniformity in operational environments as complex and varied as those found among IHS and tribally operated health programs are not possible. However, basic

standards for recording and reporting of data must be followed to ensure fairness and accuracy. Necessary data definitions and standards will be promulgated as part of resource allocation technical manuals and guidelines. These manuals and related data 'quality control measures are the responsibility of each formulae manager. However, a deeper responsibility for managing systems of data collection that will produce quality data is, shared by local managers of IHS and tribally operated programs that collect and record data and by the data processing, statistical, program and financial arms of the IHS that tabulate and report data.

- G. Consistent Application and Review. The IHS resource allocation formulae represent the formal rules whereby the funding priorities of competing areas and service units will be evaluated. The formulae are the quantitative expressions of resource allocation goals as applied to objective data from Areas and operating units that measure relevant conditions (e.g., health conditions, access and utilization of services, available funding, etc.). A consistent application of these formulae promotes fair treatment for all competing entities, even if individually some are dissatisfied with the results.

However, no set of formalized rules or formulae can ever wholly replace the need for sound programmatic experience and judgment. Ever evolving circumstances cannot be completely foreseen and considered in formulae. To minimize this problem, results should be reviewed before allocations are finalized. In the case of Headquarters allocations, results should be presented to the Council, to an appropriate Indian organization, and IHS senior management. In the case of sub-Area allocations, Area allocation results should be presented to the tribal consultation body formed for that purpose and to Area senior management. Such a review provides an opportunity and responsibility to rectify errors and compensate for unanticipated events.

- H. Local Discretion. Areas have latitude to adapt allocation methods to meet local needs and desires so long as revisions are:

- (1) consistent with the intent and purpose of the appropriated funds,
- (2) consistent with principles and methods expressed in this policy,
- (3) consistent with directions and guidance accompanying the formal advice of allowance, and
- (4) are derived through participation and consultation with affected tribes and tribal organizations.

In order to maintain reasonable consistency nationally, each Area should consider the allocation formula? employed by Headquarters as the starting 'point and as the preferred approach. In general, revisions should be limited to those adjustments that are necessary to accommodate local conditions and desires. If revisions are accomplished within the criteria specified above formal approval from Headquarters is not required.

- I. Exceptions. If in the review by staff, tribes, or the Council, strong evidence is offered that data used in formulae are inaccurate, inappropriate, or misapplied and result in substantial and material errors in the funding distribution, then alternative data may be substituted. Petitions to make exceptions should not be offered for light and casual reasons. The alternative data, in the judgment of the IHS, must be based upon sound scientific, statistical, or financial methods, must be documented and derived from readily available sources, and must be demonstrably improved over the original data. The responsible Headquarters formula manager rules on the merit of petitions made for national allocations. The designated Area formula manager rules on the merit of petitions made for sub-Area allocations.

Petitions to alter the mathematical relationships in formulae after onset of the annual application cycle must meet even more strenuous criteria. Proposals to modify formulae during the application cycle, whether for the national allocation or for Area allocations, should be made only if there is compelling evidence that formulae are inconsistent with requirements of the law or regulation, at variance with the intentions of the Congress, or are demonstrably inconsistent with the principles and objectives of this policy. This prohibition does not apply to periods before the application process has begun. It is expected that improvements and refinements of formulae would be entertained in the intervals between annual applications of resource allocation formulae.

- J. Balance. Some of the principles and objectives that govern the IHS resource allocation policy are partially in conflict. That is, it is sometimes not possible to achieve maximum success in one objective without compromising the success of another. For example, a strategy that promotes maximum cost efficiency for the health delivery system as a whole may undermine the equity in availability and access to services among individual communities.

The IHS resource allocation formulae should strike a reasonable balance among competing values and strategies. Frequently, a balanced strategy is achieved in IHS resource allocation formulae by explicitly weighting the formulae elements that represent the competing values. Generally speaking, there are no scientific or technical rules for making such judgments. Such choices must

reflect the best programmatic judgments of experienced senior officials as tempered by consideration of the IHS mission, legislative intent, and the expressed values and desires of Indian people and tribes.

- K. Reasonable Assurance. Resource allocation formulae and associated systems of procedures and data shall be executed in a manner sufficient to provide reasonable, but not absolute, assurance that their application is fair and that the objectives of the system will be accomplished. This standard recognizes that the costs of developing and approving formulae, of collecting and compiling data, and of applying the formulae should not exceed the benefits derived therefrom. Formulae should not be excessively detailed and burdensome. This implies that the details and precision of formulae should be tempered by the availability of readily accessible data. It also means formulae should be as simple as is consistent with maintaining reasonable levels of precision given the amount and importance of the funding available for allocation.
- L. Disposition of Funds. Funds allocated to Areas or operating entities must be utilized in accordance with the following principles:
- (1) Funds are used only for authorized purposes.
  - (2) Obligations and outlays are restricted to the amounts authorized.
  - (3) Funds are committed in accordance with applicable statutory (e.g., Federal Managers\* Financial Integrity Act-FMFIA) and regulatory standards (e.g., OMB Circular A-34) governing Federal budget execution and IHS policies (e.g., guidance accompanying formal advice of allowances). These include internal controls to ensure that obligations and costs comply with law, assets are safeguarded against waste, loss, unauthorized use, and misappropriation, and that revenues and expenditures are properly recorded.
  - (4) Funds are used economically, efficiently, and effectively. This means careful and prudent use of allocations to promote optimum utilization of all available resources.
  - (5) Funds allocated by formulae methods are used to benefit the operating entity or Indian service population identified in the formulae. Funds awarded on a service population basis may be used in facilities or service delivery programs located outside of the geographic service area boundaries, if such facilities are the customary sources of care for the service population and are the most appropriate and

effective sites for providing the service. If, for instance, a service area population qualifies for funding under a formula method because of deficiencies in inpatient services, awarded funds (in whole or part) may be used in hospitals located in other service areas if the targeted population is likely to use such facilities and if the recipient facility or program uses the funds to enhance inpatient services to the targeted service population.

9. GOALS AND OBJECTIVES.

- A. Elevate Indian Health. The most powerful determinant of the IHS program is its unique goal: to raise the health status of American Indians and Alaska Natives to the highest possible level. Many individuals do not recognize that this goal goes beyond providing "traditional" medical services. This goal dictates that funding policies must direct resources to better promote health of Indian people, especially in those communities with excessively poor health status or highly restricted access to health care services.

The concept of health status of whole populations, communities, and the Indian public in aggregate is critical to the understanding of IHS resource allocation policies. This concept shapes policies by establishing the ultimate objective to "improve the health of all Indian people" while minimizing inequities among Indian communities in access to and consumption of, health care services. Success of IHS resource allocation is judged; neither by whether IHS provides an identically defined package of health care services in each of its facilities, nor by guaranteeing any individual entitlement rights to a specific set of benefits. The test of success for IHS resource allocation strategies, then, is judged by whether the collective sum of the health of all Indian people is advanced.

- B. Ensure Fairness and Promote Equity. Historical precedent in IHS regarding the fair distribution of limited resources among competing interests have made this a key principle. This principle states that resources should be distributed in such a way as to avoid bias or favoritism. Alternatively, this principle can be restated as an objective to reduce discrepancies among Indian communities with respect to properties such as access to health care, consumption of services, and health status.

This objective does not mean that Indian communities always share equally in any given annual allocation. Instead, resource allocations should redress inequities so that discrepancies among communities are reduced over time. In practice, this has meant providing resources first and in greater degree to those with the greater needs.

- C. Increase Efficiency. Many laws and regulations govern the safeguarding, control, and use of Federal appropriations. One of the most basic principles underlying these is the requirement that agencies utilize resources economically and efficiently. This principle generates an important resource allocation objective.

The IHS resource allocation strategies and formulae should distribute resources in a manner that increases efficiency, productivity, and the prudent use of resources. Efficiency means getting the most out of a given input (resource). Efficiency is promoted by systems of incentives that encourage productive effort and by patterns of resource investment that maximize total products (health care services in this case). Most IHS resource allocation formulae contain explicit or implicit productivity standards.

- D. Promote Effectiveness. Federal laws and regulations also require resources to be managed for effectiveness. This means managing a program in a manner that most effectively accomplishes the intended program results. As opposed to efficiency, where the objective is to increase the units of output for each unit of input, the effectiveness objective is to accomplish the greatest improvement in the targeted external condition. The efficiency and effectiveness objectives are **not** usually in conflict, but a program that is efficient, in an output/workload sense, is not necessarily effective in accomplishing intended results and improving targeted community conditions such as health status.

Effectiveness is included in many IHS resource allocation strategies and formulae by the inclusion of outcome measures and indices. However, rigorous data on program effectiveness -- data that can causally attribute changes in external conditions to program services -- is often unavailable or unreliable. For example, some health promotion programs targeting healthful lifestyles may not produce measurable results for years or even generations. This does not mean that such programs are necessarily ineffective, only that one must wait to witness their impacts. Consequently, many IHS resource allocation formulae rely **on** targeted external conditions (e.g., health status as measured by YPLL, community mortality rates related to alcohol and substance abuse, age and condition of physical assets, etc.) rather than on documented results.

- E. Minimize Harm. In the event of funding decreases, the primary objective when distributing such decreases among Areas and operating units is to minimize harm. Generally speaking, the burden of harm from shrinking resources should be borne widely and proportionally. However, it is prudent to consider extenuating circumstances. For example, some operating units are better able than others to constrict activities without catastrophic consequences for services or patient safety. In extreme cases,

the financial viability of some operating units may be threatened. Since, most IHS resource allocation formulae are poorly equipped to measure these circumstances, their use to allocate funding decreases should be in conjunction with other supplemental information and judgment.

10. HEALTH NEEDS INDICATORS. Most IHS resource allocation formulae are designed to target resources based upon measures of need. Need is the lack of something requisite, desirable, or useful. In the health context, need refers especially to requirements for the well-being of individual people and the Indian community at large and/or conditions requiring supply or relief.

Because of the independence and self-governance of Indian tribes that derive from their sovereignty, tribes and tribal organizations have the right to define tribal health care needs that they deem appropriate to their circumstances and desires. However, resource allocation is inherently a comparative exercise that must be based on the use of common attributes in order to be fair and impartial. For purposes of resource allocation, therefore, IHS has defined uniform measures of health care need that are consistently applied to all Indian communities. Although special efforts were made to establish measures of need that fairly reflect the diversity of conditions among Indian communities, it is recognized that these measures do not always correspond to or completely fulfill the desires of individual tribes.

Through long experience, detailed study, and extensive tribal consultation, IHS has established primary indicators in the measurement of the health care needs of Indian people. In resource allocation formulae, these indicators are used as standards to compare the relative needs of different geographic service areas. Each indicator measures a different attribute or characteristic of the health care system. The major indicators of need used in IHS resource allocation formulae are:

- A. Population. All other things being equal, the health care needs of a service area is directly proportional to the number of people that are served. The most common indicator of this type is the user population count. The potential service population count is also considered in some formulae.
- B. Services. Each eligible Indian should have access to a comparable but not necessarily identical set of health care services. Commonly used indicators of services are hospital admissions, physician visits, dental visits, etc. Standards of utilization (average services consumed per person) are established to compare the general availability and use of these services among service areas. National health care utilization norms are used in some IHS resource allocation formulae to benchmark IHS standards (see dental for example). In addition to service utilization, some formulae may include measures of services covered. Such

indicators frequently account for both the scope and breadth of services that are available and their relative resource intensity. The general concept is to allocate resources in such a way as to promote equivalent utilization and coverage among Indian communities.

- C. Quality of Care. Many IHS resource allocation formulae, especially those for medical and clinical care, are developed using quality of care standards. These are diagnostic and treatment protocols that are appropriate for a given clinical condition. Standards of care also require appropriate professionally trained staff for each diagnostic and treatment protocol (e.g., a general practice physician is needed for some things, a specialist for others.) The IHS clinical staffing standards are based upon matching clinical task requirements with professional skill levels.
- D. Productivity Standards. Most IHS resource allocation formulae include labor productivity standards. These are assumptions about the amount of time necessary to provide a given service (or alternatively, the number of staff necessary to provide a given number of health care services). While the standards of care determine the appropriate professional mix considering qualifications and education, the productivity standards specify the expected or average amount of time needed to complete a particular protocol and, hence, the number of staff needed for a given number of patients with average levels of services use. Furthermore, the standards are extended to include support staff ratios. For example, a primary provider is supported by other clinical staff (Registered Nurses, Licensed Practical Nurses, etc.), ancillary clinical staff (X-RAY technologists, pharmacists, etc.), general support staff (housekeeping, maintenance, supply, etc.), and administration (bookkeepers, managers., secretaries, etc.). Normally, all labor productivity standards have a minimum threshold of workload. Most also assume some increased economies of scale as the size of the workload increases.
- E. Cost Differentials. Many IHS resource allocation formulae include or consider pricing standards and cost differentials. Staff costs are normally priced by application of the Federal pay scales (or averages based on the Federal pay scale). These are adjusted for COLAS where applicable. Some support costs are factored in as standard ratios based upon national experience. Other costs are so variable and unpredictable (at least at the scale of individual facilities), that they are simply "passed through\*" at the amounts and values actually experienced.

- F. Health Status. All other things being equal, health care needs are inversely related to the level of health status. There are several indicators of health status used in IHS resource allocation formulae. Most frequently, the health status indicator for the Indian service population is compared to the national average for all races to determine the degree of any gap. Health care needs are assumed to be larger in communities with greater gaps because of the necessity of providing additional; often more expensive, services to less healthy people.
- G. Performance Targets. Several IHS resource allocation formulae establish a standard of performance to provide incentive and rewards for certain programmatic goals. For example, the dental formula may reward an Area that serves a higher percentage of the eligible population with basic services (breadth) as compared to an Area that serves a smaller percentage with more complete services (depth).
- H. External Conditions. Some IHS resource allocation formulae incorporate measures of external conditions that are not directly patient related. For example, sanitation facilities construction formulae include measures of the number and condition of Indian housing. Similarly, formulae related to health care facilities and equipment replacement consider the age and condition of the physical plant and its equipment. In recent years, a number of proposals to include measures of socio-economic status as proxy measure of health status and health care needs have been made. Such measures are under study and will be duly considered after consultation with Indian tribes.

11. POLICY. It is the policy of the IHS that the allocation of resources available to IHS will be accomplished within the authorities and guidelines noted and/or described in this circular.

The allocation of resources must be accomplished within the following principles:

- A. Allocations must comply with existing judicial, statutory, and regulatory requirements.
- B. Allocations must be consistent with congressional intent.
- C. Allocations must comply with HHS, PHS, and IHS policies.
- D. The classification of resources, when allocated, will be designated recurring and/or non-recurring.

- E. The Council will participate in the national resource allocation process by reviewing and approving recommended allocation methodologies to the Director, IHS, including amounts, purpose, and funding source for establishing the operating reserves.
- F. Officials that manage the application of any resource allocation formula must ensure the integrity, consistency, and timeliness of the allocation process. This includes fully describing and documenting the formulae and distributing technical manuals that detail the associated process and procedures to Area offices. Furthermore, any guidance for Areas on the allocation, use, or disposition of funds must be developed and provided for inclusion in the advice of allowances.
- G. Areas that are the recipients of allocations are responsible for sub-Area allocations consistent with this policy and for the integrity, consistency, and timeliness of allocation processes. While flexibility in the secondary allocation is allowed in order for the Areas to better address its specific needs, Area allocations must conform to any guidelines accompanying the formal advice of allowance and principles prescribed in this policy. Consideration will be given to the guidance accompanying allocations that describe the congressional intent for the funds and the preferred formulae suggested by Headquarters.
- H. Resource allocation will be accomplished with meaningful consultation with tribes and tribal organizations. Consultation must occur at three levels:
  - (1) Level I - Broad consultation will occur during the development of national resource allocation formulae and methods.
  - (2) Level II - Results from the application of national allocation formulae will be presented to the appropriate national Indian organization.
  - (3) Level III - Consultation with tribes or tribal organizations within Areas will occur prior to the approval of sub-Area allocation formulae and results.
- I. Recording and documenting the final disposition of resources within Area allocations for each fund is required. Final sub-Area allocations, funding disposition and methods used to make the allocations must be reported to the appropriate Headquarters formulae manager. Headquarters will compile this information for reporting back to the Congress.

12. PROCEDURES. The following steps must be considered in implementing the IHS resource allocation process:

A. Actions required by IHS prior to enactment of an appropriation bill.

- (1) A meeting of the Council to develop recommendations for allocating resources for the next fiscal year must be accomplished.
- (2) Decisions on level of funding to be utilized in negotiating renewal of tribal contracts must be made.
- (3) A determination of the recurring funding bases for Headquarters and for each IHS Area by budget category is finalized.

B. Actions taken upon enactment of continuing resolution or annual appropriation.

(1) Continuing Resolution (CR).

- (a) Evaluation of CR language is complete.
- (b) The IHS Headquarters' and Area's annual recurring funding bases are adjusted in accordance with CR.
- (c) If required, the IHS proposed apportionment, that reflects area spending plans, is completed and submitted to OMB, through the appropriate organizational channel, for approval.
- (d) Area allocation documents are developed reflecting the period of times covered by the CR computed on the adjusted annual recurring funding bases noted in I(b) above.
- (e) Allocations are issued to IHS Areas with accompanying instructions as received from PHS, HHS, or OMB.
- (f) All of the above is repeated for each CR enacted for less than a year.

(2) Regular Appropriation.

- (a) An evaluation of the language contained in the House, Senate, and Conference Reports on Appropriation and in the Appropriation Act is completed.

- (b) The IHS Area annual recurring funding bases are adjusted in accordance with the evaluation in B.1.
- (c) Other funding commitments are finalized for such program, project, or activities as physician recruitment efforts, evaluation of IHS progress, special training programs, etc., and a determination of the amounts to be allocated under all of the various resource allocation formulae is made.
- (d) Apportionment of funds request is submitted to OMB, through the appropriate organizational channels for approval.
- te) The IHS Headquarters' and Area's funding bases are adjusted to reflect OMB apportionment decisions.
- (f) Allocation documents are finalized based on amounts adjusted to reflect OMB decisions and issued to IHS Headquarters and Area Offices with special instructions and explanations, i.e., exclusions and inclusions.
- (9) Additional allocations are issued throughout the fiscal year.
  - (1) The funds placed in reserve for a specific program, project, or activity are allocated throughout the year based on an approved plan.
  - (2) The funds placed in reserve as undistributed for urgent or emergent contingencies are allocated based on need. Any balance remaining after July 31 of the current year will be allocated utilizing applicable resource allocation formulae.
- (3) Actions taken to allocate remaining resources. The allocation of resources will be accomplished through the following steps:
  - (a) By close of business (COB) on the fifth working day in August, the Associate Director, Office of Administration and Management (OAM), will identify, document, and submit to the Deputy Director, IHS, an inventory of all funds potentially available for allocation in the fiscal year beginning on October 1, of the same year. This would include such funds as mandatory cost increases, population growth fund, Indian Health Care Improvement Fund, funds for newly Federally recognized tribes, etc.

- (b) The Director of Headquarters Operations (DHO), INS, and Associate Directors will develop proposed resource allocation methodologies for each fund identified in Step 1 for presentation to the Council. In addition, the DHO and Associate Directors will develop proposed operating reserves for each sub-sub-activity for presentation to the Council. This will include, for each proposed reserve item, the amount, purpose, funding source, and allocation methodology.
- (c) The Deputy Director, IHS, will meet with Associate Directors and/or formulae managers to establish the schedule and timetable for completing resource allocation formulae applications.
- (d) The Council will meet in August to discuss and establish recommendations on resource allocation methodologies for use in distributing all IHS resources identified by the Associate Director, OAM. In addition, the Council will also establish recommendations on operating reserves identifying their purpose, amount, and funding source.
- (e) The Council, through the Deputy Director, IHS, will formally present the Council recommendations to the Director, IHS, for approval and/or other action.
- (f) The Director, IHS, will officially act on the Council's recommendations on the resource allocation methodologies and on setting the Headquarters' reserves. These actions or decisions will be transmitted to, the Deputy Director, IHS, for implementation.
- (9) The Deputy Director, IHS, will communicate the Director's decisions to the Council for informational purposes and as appropriate for implementation. The Deputy Director, IHS, will specifically notify the DHO, IHS, and the Associate Directors of their respective responsibilities and timetable with regard to the application of the allocation methodologies and to administering and/or coordinating the operating reserve funds.
- 10) Upon receipt of the annual appropriation, as applicable, the Associate Directors will ensure that allocation methodologies are applied fairly and consistently. Results will be provided to the Council and the appropriate national Indian organization.

After obtaining all necessary approvals, results are provided to the Associate Director, OAM, for actual allocation by the DRM. The Associate Directors will also prepare an allocation plan for each program, project, or activity in reserve that identifies the recipient(s) of the fund, the month of the fiscal year in which the allocation is planned to, occur, and a distribution of the amount by object class. This plan will be submitted to the Director, DRM, to support the apportionment as well as managing the reserves.

- (i) Upon acquiring all necessary approvals, the Associate Director, OAM, will provide information to DRM for preparation and issuance of Advice of Allowances.
- Cj) The Director, DRM, will prepare, and issue HHS 626, Advice of Allowances, to the appropriate allowees, ensuring the allowances are within the limits of apportioned funds and in compliance with other fund control and Antideficiency Act requirements. The Director, DRM, will also provide monthly status reports on allocations to the appropriate IHS officials.

13. RESPONSIBILITY. The responsibilities and functions of the individuals who play a major role in the determination and execution of the IHS resource allocation process are varied. They represent all of the functional responsibilities assigned to IHS in both Headquarters and Area Offices. They are as follows:

- A. Director, IHS. The Director, IHS, as the sole allottee with statutory responsibilities for the administrative control of funds and as the individual charged with the responsibility for carrying out the overall program requirements of IHS, maintains the approval authority for the determination and execution of the IHS resource allocation process. The Director, IHS, or his designee will approve the commitment and/or allocation of operating reserves set aside for emergency or contingency purposes.
- B. Deputy Director, IHS. The Deputy Director, IHS, is designated as the principal official charged with carrying out the responsibilities of the Director, IHS, on all aspects of allocating IHS resources. The Deputy Director establishes the timetable for all allocations (e.g., recurring base, built-in increases, formulae methods, etc.) to the Areas for each sub-sub-activity budget.
- c. Director of Headquarters-Operations. the DHO will ensure that Associate Directors develop proposed resource allocation

methodologies applicable for each available fund within the framework of this policy and with the meaningful consultation of appropriate Indian organizations. The DHO along with the Associate Directors will also develop the proposed operating reserves for presentation to the Council. This will include, for each proposed reserve item, the amount, purpose, funding source, and allocation methodology.

- D. Council of Area and Associate Directors. Prior to the beginning of each fiscal year, the Council will meet and establish recommendations on allocation methodologies to be used in distributing all IHS resources and on establishing the operating reserves, including their purpose, amount, and funding source.
- E. Associate Directors. The Associate Directors are responsible for completing the application of the approved resource allocation methodologies for final dispensation and for administering or coordinating the allocation of the approved Headquarters' reserve funds. The Associate Directors are required to accomplish the task within a specified time schedule identified by the Deputy Director. For administering the allocation of operating reserve funds, the responsible Associate Director is required to develop and submit an allocation plan including the recipient of the reserve fund, the month of the fiscal year in which the allocation is planned to occur, and a distribution of the amount by object class. Associate Directors will designate formula managers for those accounts that fall within their responsibility. Associate Directors are responsible for obtaining meaningful consultation during the development of IHS resource allocation formulae.
- F. Formula Managers. As designated by the appropriate Associate or Area Director, formula managers have the responsibility to carry out the application of such formulae as assigned. These include the formula manager responsibilities described elsewhere in this circular including all the duties necessary to provide sufficient guidance and technical assistance to Areas, data definition, quality control for data collection, consistent application of formulae, and documentation and recording of results. Headquarters formula managers are responsible for providing results to the Council and to designated Indian organizations. As appropriate, formula managers will be designated for the following formulae:
- (1) Hospital & Clinics (H&C) Area Resource Allocation  
Methodology (ARAM) - Office of Planning, Evaluation and  
Legislation (OPEL)

- (2) H&C Population Growth Formula - OPEL
- (3) H&C Health Services Priority System (HSPS) Formula - OPEL
- (4) All Contract Health Services (CHSI Formulae - Office of Health Programs (OHP)
- (5) Dental Formulae, - OHP
- (6) Public Health Nursing (PHN) Formula - OHP
- (7) Contract Indirect Cost Formula - Office of Tribal Activities (OTA)
- (8) Mental Health Formulae - OHP
- (9) Alcoholism Formulae - OHP
- (10) Health Education Formulae - OHP
- (11) Urban Health Programs Formulae - OHP
- (12) Community Health Representative (CHR) Formulae - OHP
- (13) Health Care Facility Priority System - Office of Environmental Health and Engineering (OEHE)
- (14) Environmental Health Services Formula - OEHE
- (15) Sanitation Facilities Formula - OEHE
- (16) Maintenance and Repair Formula - OEHE

G. Associate Director, Office of Administration and Management.

The Associate Director, OAM, has the primary responsibility for implementing the administrative control of funds system and, therefore, is responsible for ensuring compliance with the resource allocation policies prior to the actual funds allocation by the DRM. In addition, each year the Associate Director, OAM, is responsible for identifying all categories of funds available for allocation for which the Associate Directors will prepare proposed allocation methodologies for presentation to the Council.


H. Director, Division of Resources Management. The Director, DRM, is responsible for the preparation and issuance of HHS 626, Advice of Allowances, to the appropriate allowees and ensuring the allowances are within the limits of apportioned funds and in compliance with other fund control and Antideficiency Act requirements.

I. Area Directors. The Area Directors, the Associate Director, Office of Health Program Research and Development, and the Program Director, Albuquerque Headquarters West, are the officials charged with the responsibility of carrying out the overall program requirements within their Areas. This responsibility includes the allocation of Area resources among operating units. The Area Director, or his/her designee, is responsible for managing

application of sub-Area resource allocation formulae consistent with this policy. Included is the responsibility to ensure the integrity, consistency, and timeliness of the Area allocation process. The Area Director is responsible for ensuring meaningful tribal consultation in the development of sub-Area allocations, and for documenting and reporting sub-Area allocations to Headquarters.

- J. Local Health Care Officials and Administrators. Local administrators and officials (Service Unit Directors, Contract Administrators, Program Officials, etc.) are responsible **for** utilizing allocated resources consistent with their purpose and with the regulations and policies that govern the administrative control of funds.

14. IMPLEMENTATION. The guidance contained in this circular is applicable beginning with fiscal year 1993.

  
Everett R. Rhoades, M.D.  
Assistant Surgeon General  
Director, Indian Health Service